STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005100	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL OF ANDERSON AND MADISC	1515 N MADISON AVE ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00106510 Unsubstantiated: Lack of sufficient evidence. Date: 6-26-12 Facility Number: 005100 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Community Hospital of Anderson and Madison County is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.6.2, Emergency services, Indiana Hospital Licensure Rules. QA: claughlin 06/29/12	S 000		